GP Delivery Improvement Framework

Name of Area: Frailty

April 2024 to March 2025

Lancashire and South Cumbria ICB

1. Rationale

Frailty is defined by the British Geriatric Society (BGS); 'Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves.' The society estimates that around 10 per cent of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85.

There are approximately 140,000 people living in Lancashire and South Cumbria who have mild to moderate frailty with health and wellbeing concerns that are amenable to low grade but timely interventions. Many of the needs identified are psychological and/or social and are reversable with information, education or referral to onward care and support services. These include the voluntary sector and/or Council commissioned services, such as reablement or leisure activities or community services such as physiotherapy. A proactive referral at this stage will result in fewer referrals at a later stage when problems have escalated. The overall vision for proactive care planning is a whole system change.

National challenges:

- Increasing numbers of people are at risk of developing frailty. A person living with mild frailty has **twice** the mortality risk of a fit older person.
- People living with mild, moderate or severe frailty could often have their needs met best in settings outside of acute hospital care. Severe frailty often brings over four times the costs of non-frailty. More people living with mild, moderate or severe frailty are attending emergency departments, with over **4000 admissions daily for people living** with frailty.

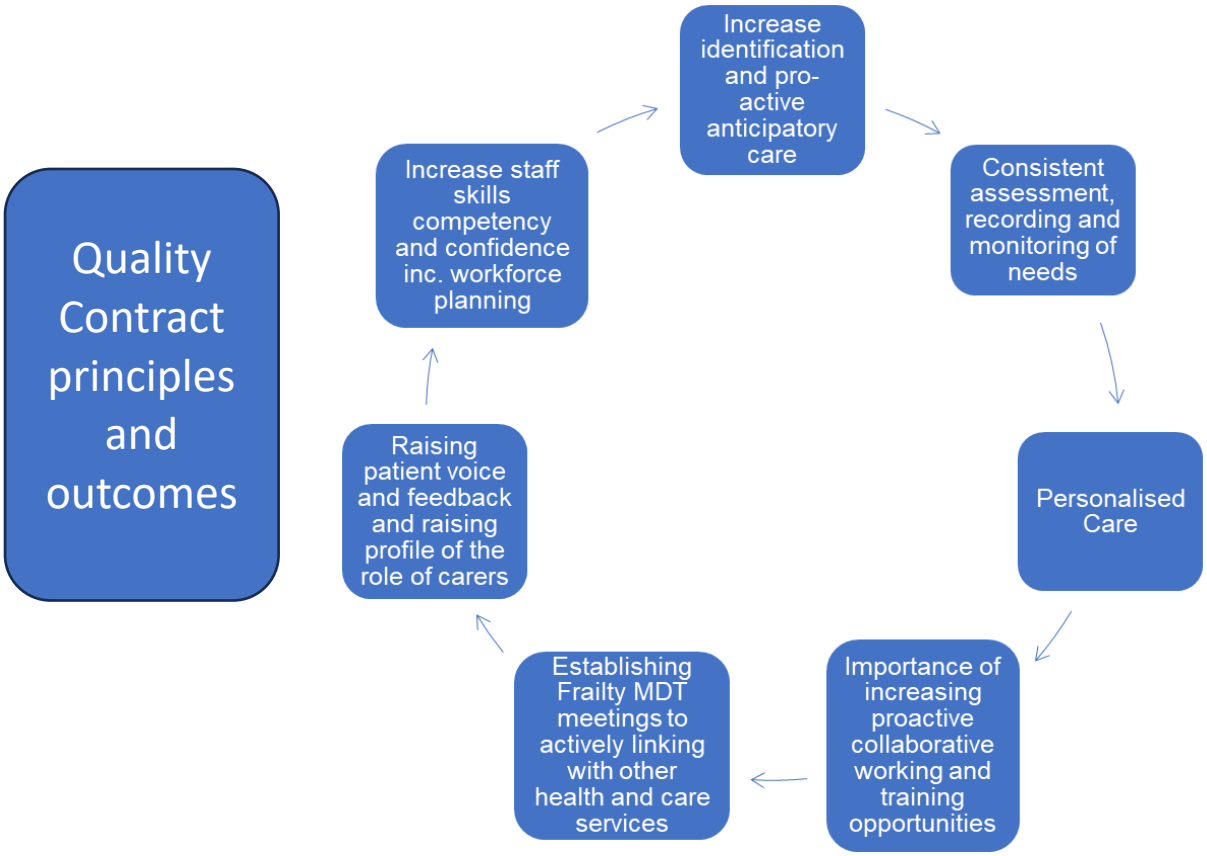
Engineering Better Care (EBC) is a national programme which has been delivered across all the acute hospitals in Lancashire and South Cumbria and is focussed on frailty. EBC describes the development of a systems approach to health and care design and continuous improvement, taking inspiration from both the healthcare and engineering sectors.

From a national strategy perspective, the **Fuller Stocktake: Next Steps for Integrated Primary Care** (May 2022) outlines the key interdependency between primary care supporting frail patients and linking with the developing Integrated Neighbourhood Team (INTs) model. The report draws upon the opportunity that INTs create to maximise support to our most frail 'We believe that through the continued development of Integrated Neighbourhood Teams, we have the opportunity to increase the focus on frailty, with increased attention paid to assessing suitable patients, developing care plans and proactively managing individuals to stay well and reduce demand on services.' This will require system cohesion for frail people to identify, assess and support people to access services, treatment and advice to enable their unmet needs to be met by a range of health, care and VCFSE sector services.

The NHS Long Term Plan sets out an evidence-based framework of care for older people with frailty to be delivered through the national Ageing Well programme. This focuses on delivering integrated personalised care in communities and addresses the needs of older people with three inter-related service models centred on clearly identifiable patient cohorts which include Community multidisciplinary teams, Urgent Community Response and Enhanced health in care homes.

2. Aim

The aim of the contract is to take a consistent approach in primary care to enhance the quality of support to mild and moderately frail people and sets the ambition to increase the level of identification, assessment and service delivery responses. To provide an integrated, personalised care model that meets people's needs, keeps them well and connects them to services and support available within their local community or neighbourhoods to keep them well in their own home.



3. Quality Contract Aims and Quality Outcomes

Our aim is to support the ICB's statutory duty to improve **outcomes** in population health and tackle inequalities in **outcomes**, experience and access through designing a new quality specification which focuses on the important role of primary care as the first point of contact for patients who are beginning to become mild/moderately frail.

We have **4** aims:

1.System – to reduce inequality of access to advice, information and services for people at an earlier stage of a frailty episode and take a personalised approach to meeting their health and care needs in their community and home. We are ambitious and have set a practice level individual numerical target to increase the identification, holistic assessment and to support the connection of people with the services they need to meet their holistic needs.

2.Levelling up – The work of the engineering better care aims to reduce the variation across all practices in Lancashire and South Cumbria to ensure that there is a consistent, equitable and efficient service offer to our people in our communities. To ensure that patients and carers receive an excellent quality and level of service across all our places and are accessible for everyone - nobody should be disadvantaged or discriminated against. Connecting our frail people with local services and integrated neighbourhood teams and closely monitoring the impact on how the collaborative working will impact on developing a truly integrated primary, community and secondary care system.

3.Individualised quality care – To utilise population health and practice level data to identify and provide good quality delivery of care so that patients are identified early, consistently assessed, and connected into wider health and wellbeing services (including the VCFSE sector) to meet their unmet need. The outcome is to enable them to live more fulfilling lives and feel more connected to our communities and the professionals who support them.

4.Listening and learning – proactively encouraging patients and carers to be part of their solution to actively promote the development of frailty champions across Lancs & South Cumbria. The outcome is to raise the profile and engagement of our frail population and by encouraging and promoting primary care staff to actively learn and complete Skills for Health e-learning and local training opportunities through our acute sector to build knowledge, skills, and empathy within professionals across organisational boundaries.

Please note that following the practice engagement and feedback process it has been highlighted that there is a lack of MDTs on the Fylde Coast and therefore a change has been made to the payment for this area. To support the development of MDTs we have included £1.50 per weighted head of population within bundle 3 specifically for Fylde Coast practices

Delivery / Outcome (1)

Population identification and stratification of frailty

Identification and stratification of the population living with frailty by needs and not just their age is essential. This allows us to work across health and social care, that can support joint priorities, and integrated and personalised care.

Practices will utilise a standardised approach to frailty and population segmentation via the Electronic Frailty Index (EFI) and a Rockwood score to identify people living with frailty and to target those who are most at risk.

Standardised way of identifying frailty:

- Use the Electronic Frailty Index (EFI) to determine and identify the patient/s with mild to moderate frailty. The EFI score identifies an individual who may be living with frailty, direct clinical assessment and judgement should be applied to confirm a diagnosis. GP practices to utilise the ICB protocol to Batch add the coded EFI score for patients aged 50 years plus. *Details on how to do this can be found in the MLCSU resource guide.*
- Practice to complete the EMIS search on EFI score to proactively identify all new frail patients who may have had an attendance/admission to secondary care in the previous 12 month period and have not already had an Rockwood score diagnosis.
- The number of patients identified and assessed should be reported on a quarterly basis as outlined in the annual performance template.
- Use EMIS template to complete a proactive frailty assessment on those identified as mild/moderate frailty using the searches and template provided by the MLCSU Data Quality Team. *Details on how to do this can be found in the MLCSU resource guide.*
- Identified patients (as clinically appropriate) should have a Rockwood score and a clinical review to formally **diagnose** the patient as mild/moderate/severe frail using the following SNoMed codes:
    - 925791000000100 |Mild frailty (finding)|
    - 925831000000107 |Moderate frailty (finding)|
    - 925861000000102 |Severe frailty (finding)|

- Ensure all staff undertaking proactive frailty assessments/ Rockwood score have completed the specified Frailty training/e learning outlined in bundle 4 of the specification (Assessment can be undertaken by non-medical staff e.g. SPLW, Health and Wellbeing workers, HCAs).

Please note: There are currrently no SNoMed invitation codes available, therefore a systematic approach should be taken when inviting patients in for an assessment, such as using surname, month of birth or age bands. 2 x invitations should be made, at least 7 days apart and where a patient does not respond to these requests a declined code can be added. Practices should invite patients using the most appropriate method according to the population.

Measurement (1)

Outcomes:

- Consistent utilisation of identification and holistic assessment of frail patients which is regularly reviewed to identify new frail patients to provide the right care, at the right time, at the right place.
- Improvement in recording of mild to moderately frail patients on EMIS and increased numbers of patients with a frailty problem code.
- Reduction in mild/moderately frail people attending the acute attendance/admissions and support them to remain at home supported by primary and community services.

Key Performance Indicators:

Practice to complete template to provide evidence of:

1. Evidence of achievement of individual practice target at year end and evidence quarterly of performance against target based on the number of mild/moderate patients identified and holistically assessed by practice.
2. Evidence of quarterly practice EMIS EFI search and complete accurate coding for mild to moderate patients.

Delivery / Outcome (2)

Supporting people with mild frailty and encouraging them to 'age well'

It is important to prevent or delay the onset of mild/moderate frailty and to be proactive in supporting people living with frailty or at risk. Recovery or rehabilitation could prevent progression in loss of functional ability. When people are ageing well it is important to encourage and support people to maintain a high level of health and wellbeing, especially considering that frailty starts earlier and progresses more rapidly in socio-economically deprived areas.

Self-care and ageing well:

- Practices to promote to **all staff** via practice meetings frailty self-management education to support staff to recognise frailty earlier on and have information to help frail patients age well. Utilise all national and local resources including the power point (see attached) which provides advice and guidance from community Pharmacy, Optometry, and Dentistry (POD) schemes and services.
- Develop frailty self- management messages **for patients/carers** and promote services available within the local community to enhance patient activation and empowerment.
- Ensure strategies are in place for the routine identification of carers so that they are appropriately supported through local carer support and voluntary and community-based services.
- Practice to provide case studies to demonstrate the aims of positive multi-agency and patient outcomes, referral pathways and unmet needs with a clear focus on carers and reflection on learning and any actions taken.

Measurement (2)

Outcomes:

- Increase partnership working with public health, housing, community and voluntary sector partners (for example: Age UK) to utilise well established self-care messages and information to create strong links and earlier interventions for frail people and their carers.
- Increase staff confidence to identify the frail and their carers and enable them to utilise information, advice and guidance from community pharmacy, optometry, and dentistry to help frail patients age well.
- Increase advice, information and support for carers and refer onwards to relevant carer support services.

Key Performance Indicators:

1. To actively promote staff and patient self-management education (inc. POD advice and guidance see embedded doc at bottom of this section) through practice meetings. This must include building on what is already in place through active promotion of the range of services in the community/voluntary sector to enhance patients and their carers motivation and empowerment to address their wider health and wellbeing issues. Practice to identify carers, show evidence and actions taken to support them to access services and insert onto annual template provided.
2. Provide one or more case studies using the template provided to demonstrate the aims below. The case(s) identified should be based on mild to moderately frail individuals your practice has supported. We want you to cover all the below elements in your case studies and therefore may require you to complete more than one.
    - Positive multi-agency input that achieved positive patient outcomes.
    - Demonstrate through the case study how the practice utilised local services and/or referred to the INT/MDT.
    - Include how any unmet health and wellbeing needs (e.g. mental health) were managed.
    - Ensure additional focus on carer needs and how the practice has supported carers to access local services.
    - Reflect how the learning from the case study will be disseminated through the practice.

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Delivery / Outcome (3)

Supporting people living with moderate frailty – MDT's & Personalised Care

It is estimated that 12% of people aged 65 or over are living with moderate frailty. The key aim to this bundle is to provide integrated multidisciplinary teams (MDT) to support people to access a range of support services such as rehabilitation, mental health support and older peoples services to prevent further progression of their frailty.

A personalised care planning approach should be utilised to address the full needs of the individual, including wider social/care issues such as housing and financial management that may impact on an individual's health and wellbeing.

- Practice/PCN to develop and engage in a monthly MDT meeting (this could be an established/existing MDT meeting) with key partners to assess/risk stratify patients with 3 or more unmet needs following holistic assessment. MDT meetings must include attendance from wider partners/stakeholders such as community frailty teams/mental health services, VCFSE sector reps/ Age UK/ housing/community services incl. frailty teams/nurses).
- MDT meetings should continue for individuals on an on-going basis until frailty status stabilises or improves, and/or until identified risks are appropriately managed.
- All patient supported by the MDT to have a proactive care plan developed which encompasses their personalised holistic needs.
- Proactive care is personalised and co-ordinated multi-professional support and interventions for people living with complex needs. Completion of a Modified Proactive Care plan (PCP) to be inserted on patient records (template embedded in EMIS). The specific aims of proactive care are to improve health outcomes and patient experience by:

  - delaying the onset of health deterioration where possible
  - maintaining independent living
  - reducing avoidable exacerbations of ill health, thereby reducing use of unplanned care.

Measurement (3)

Outcomes

- To improve health outcomes and patient experience by delaying the onset of health deterioration where possible, maintaining independent living and reducing avoidable exacerbations of ill health, thereby reducing use of unplanned care.
- established well attended frailty MDT frailty meetings to co-ordinate personalised care plans to provide the right care, at the right time, in the right place.
- Collaborative working across health, care and VCFSE sector to maximise referral pathways/activities to meet wider needs of mild to moderate patients and their carers.
- To work in a collaborative manner to engage with in depth and multi-agency conversations about improving support and treatment for people who are frail.

Key Performance Indicators:

1. Work with partner organisations/services to incorporate frailty into an existing MDT OR implement a monthly MDT meeting with a focus on frail patients and their carers. The MDT should be held on a PCN wide basis (where possible) and have regular attendance and engagement from a range of health, care and VCFSE sector professionals such as Age UK. Practice/s to provide a list of organisational reps attending MDT meetings within the annual template.

2. Patients who have a holistic assessment and have 3 or more unmet needs identified, must be reviewed and referred into the practice/PCN MDT where appropriate.

3. To provide the total number of patients identified as suitable for referral to the MDT and the number of Proactive Care Plans completed for those patients. Ensure

50% of patients referred to MDT complete a patient experience feedback survey (can be via text messages). Utilise the feedback from the survey to conduct a 6 monthly review to consider practice and PCN quality improvement opportunities to the service.

Information to be above 3 KPI's to be completed on the annual performance template.

Delivery / Outcome (4)

Raising awareness of frailty through education and staff skills

Demographic change means that the majority of the health and care workforce will care primarily for older people, and therefore need the knowledge and skills to be able to deliver care and support for older people, regardless of their specialty. Support to increase the education and training in frailty as a specific condition, and enhanced knowledge and expertise in caring for people with multiple long-term conditions, are essential if we are to have a workforce that can meet the changing healthcare needs of our ageing society.

There are a range of training and e-learning opportunities which all practice staff are able to access to increase knowledge and skills in their role supporting our most frail. See summary of key learning opportunities below:

1. The Skills for Health Frailty Core Capabilities Framework provides a single, consistent and comprehensive framework on which to base staff development. The framework builds on, and cross-references, other core skills frameworks for dementia, end of life care and person-centred approaches. The framework can be accessed via this link: Frailty (2018) | Skills for Health

2. British Geriatrics Society developed a Frailty E-Learning module which covers the skills, knowledge and behaviours expected of healthcare professionals involved in the health, care and support of people living with frailty. The e-learning module can be accessed via this link: 2023 Frailty: Identification and interventions | British Geriatrics Society (bgs.org.uk)

3. Access the Frailty "Speed dating training" GP/PCN Level training created for the Engineering Better Care created by Pennine Lancashire Team – further details to follow.

4. Ensure all practice staff have access to and standardise the use of the Frailty Personas in order to raise awareness and early recognition of frail people. (See persona document below).

Measurement (4)

Outcomes

- To increase skills, knowledge, confidence and competency for practice staff to identify frail patients at an earlier stage and align training to the workforce development plans.
- Equip staff to utilise the ELHT Frailty Persona to support staff to recognise different frailty levels at an earlier stage and utilise this as a day to day tool in practices.
- Develop a network of 'frailty champions' to develop a key role in promoting a consistent and universal awareness and understanding of frailty and related issues/needs across health, social care and VCFSE sector professionals.

Key Performance Indicators

1. Practice to identify key staff members to undertake frailty e learning training on skills for health (as per 3 options above) as a minimum we would expect staff who are: undertaking assessments, nursing staff, key administrative, care coordination/navigators, social prescribers and those as deemed appropriate by the practice to undertake the training package.
2. All clinical and non-clinical practice staff to have access to the Frailty persona document to build knowledge and skills across the practice.
3. Practices to develop a frailty champion and work with other champions across the PCN, with a key role of promoting a consistent and universal awareness of frailty (including end of life) across health, social care and VCFSE sector professionals.

Frailty levels personas with changes for EL demographic (1).pdf

5.2 Frailty Poster Aug 23.pdf

Resources

Include here any links to documents, NICE guidance, national guidance, other support etc.

Right care Challenges Ref: PowerPoint Presentation (england.nhs.uk);

British Geriatric Society 2023 joining the dots; A blueprint for preventing and managing frailty in older people https://www.bgs.org.uk/policy-and-media/joining-the-dots-a-blueprint-for-preventing-and-managing-frailty-in-older-people

NHS RightCare: Frailty Toolkit 2019 NHS England https://www.england.nhs.uk/right-care/wp-content/uploads/sites/40/2019/07/frailty-toolkit-june-2019-v1.pdf

Engineering Better Care Workshop Summative presentation – September 2023

EBC Workshop 4 summative presentation FINAL.pdf